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Grievance System
Grievance, Appeal, and State Fair Hearing Processes for a CRS Enrolled Member

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Grievance, Appeal, and State Fair Hearing Processes for a CRS Enrolled Member

60.000 Grievance, Appeal, and Hearing Processes For A CRS Enrolled Member

60.100 Purpose

This chapter presents the CRS Programôs grievance, appeals, and administrative hearing processes for CRS enrolled members. This policy does not apply to actions or decisions that reduce a memberôs CRS benefits as a result of changes in state or federal law.

60.200 General Standards

60.201 Policies

1. CRS Regional Contractors shall maintain internal policies and procedures for grievance and appeal resolution processes that meet CRSA standards as described in this chapter.
2. Members and/or their representatives shall be informed about grievance and appeal procedures at the time of eligibility contact, upon request, or when changes occur in the policy.
3. Providers shall be given a copy of the member grievance and appeal policies at the time of contract, upon request, or when changes occur in the policies.
4. The CRS Regional Contractors shall ensure that punitive action is not taken against a provider who supports a memberôs grievance, or appeal, or who requests an expedited resolution to an appeal.
5. The CRS Regional Contractors shall ensure that individuals who make decisions on grievances and appeals are individuals:
   A. Who were not involved in any previous level of review or decision-making, and
   B. For medical necessity decisions or cases involving clinical issues, are health professionals who have the appropriate clinical expertise in treating the memberôs condition or disease.

60.202 Records

1. All records obtained for the CRS Program grievance and appeal processes are filed separately in a secure, designated area, and are retained in reproducible format for a minimum of six years.

2. The files must contain documentation of all acknowledgment, investigation and resolution activities related to each grievance and appeal.

60.203 Date of Filing

1. CRSA and the CRS Regional Contractors will consider the grievance, appeal, or State Fair Hearing request as filed on the date it is received by CRSA or the CRS Regional Contractor.
2. All written grievances and appeals and any incoming correspondence related to grievances and appeals must be date stamped upon arrival.

60.204 Reasonable Assistance

1. A CRS Regional Contractor shall provide reasonable assistance to members in completing forms and taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications device for the deaf, and text telephone) and interpreter capability.

60.205 Computation of Time

1. Computation of time in calendar days begins the day after the act, event, or decision and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.
2. Computation of time in business days begins the day after the act, event or decision and includes all business days.

60.300 Grievance Process

60.301 Who May File

1. A Member or a memberôs parent or guardian may file a grievance.
2. A provider who is acting as the memberôs authorized representative may file a grievance on behalf of a member with the written consent from the member.

60.302 Time Frame for Filing a Grievance with CRSA or CRS Regional Contractor

A grievance, either orally or in writing, may be filed with CRSA or the CRS Regional Contractor at any time. As CRSA desires to have issues resolved as expeditiously as possible, the member or his/her representative should be encouraged to file directly with the CRS Regional Contractor.

60.303 Time Frame for Standard Disposition of a Grievance

1. The CRS Regional Contractor shall acknowledge receipt of each grievance orally or in writing no later than five (5) business days after

receipt. Potential quality of care concerns must have written acknowledgement.

2. The CRS Regional Contractor shall complete disposition and provide oral or written notice to the member of the grievance resolution as expeditiously as possible. Potential quality of care resolutions require a written notice to the grievant. Most grievances should be resolved within ten (10) business days; but, in no case longer than ninety (90) calendar days.

60.304 Grievance Resolution

1. CRS Regional Contractors shall have written policies and procedures for reviewing, evaluating and resolving grievances, regardless of who within the organization receives the grievances, that include:

   A. Documenting each grievance raised, when and from whom it was received;
   B. That is the responsibility of the CRS Regional Contractorôs Quality Management Coordinator to make a prompt determination of whether the grievance is a non-quality of care concern or a quality of care concern and assigning a severity level (Severity levels are defined at the back of this chapter. Zero equals non-quality of care and one and above equal quality of care issues);
   C. Determining priority status (See definitions at the back of this chapter);
   D. That all Quality of Care Issues are resolved in compliance with Ch. 80, Section 80.302;
   E. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue;
   F. Ensuring confidentiality of all member information; and
   G. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance on both an individual and system level, including but not limited to:
      1) Interventions, including the provision of immediate medical needs as approved by the CRS Regional Medical Director;

      2) Monitoring of the outcome of the interventions;

      3) Incorporation of the interventions, if successful, into the CRS Regional Contractor system of care to reduce/eliminate the likelihood of the issue reoccurring;

4) Follow-up with the member that includes, but is not limited to:
   a) Assistance as needed to ensure that the immediate health care needs are met; and
   b) Closure/resolution letter on the Regional Contractorôs letterhead that provides sufficient detail to ensure all covered, medically necessary care needs are met; contact name/title and telephone number to call for assistance or to express any unresolved concerns; the name, title and credentials of the person signing the letter; and, if applicable, the Memberôs AHCCCS ID number.
      i. For non-quality of care resolution letters use letter #3, found at the back of this chapter, as a template;
      ii. For quality of care resolution letters use letter #4 as a template.

H. Documenting closure of the review.

2. Additional actions by the Regional Contractors may be necessary, based on individual case circumstances, before a case is closed. These actions may include:
   A. if the case was received from CRSA or if CRSA desires to review the investigative steps and proposed resolution, submission of the entire file with all documentation to CRSA;
   B. referring/reporting the issue to appropriate regulatory agency, AHCCCS, Child or Adult Protective Services and CRSA for further research/review or action;
   C. notifying the appropriate regulatory/licensing board or agency and CRSA when a health care professional's, organizational providerôs or other providerôs affiliation with their network is suspended or terminated because of quality of care issues;
   D. additional interventions/approaches if the original intervention is not successful or additional actions are required to fix the system;
   E. in-services documented through attendance sign-in sheets and notes;
   F. new policies and procedures; and/or
   G. referral to the CRSA Peer Review Committee.

60.400 Appeal Process

60.401 Who May File

1. A Member or a memberôs parent or guardian may file an appeal.

2. A provider, acting on behalf of the member, with the memberôs written consent, may file an appeal.

60.402 Requirements for Appeal Process

1. The CRS Regional Contractor shall acknowledge receipt of each appeal in writing no later than five (5) business days after receipt of a standard appeal and within one business day of receipt of an expedited appeal.
2. The CRS Regional Contractor shall provide a reasonable opportunity for a member or his/her representative to present evidence, and allegations of fact or law, in person and/or in writing. The CRS Regional Contractor shall inform the member of the limited time available for such presentation in the case of an expedited resolution.
3. The CRS Regional Contractor shall provide the member and representative the opportunity, before and during the appeal process, to examine the memberôs case file, including medical records, documents, and records considered during the appeal process, not protected from disclosure by law.

4. The Regional Contractor shall notify CRSA immediately if the appeal request makes mention of any quality of care issues of severity level two or above.

5. All letters sent out during the appeals process shall follow the language of the appropriate templates found at the back of this chapter; be sent on the Regional Contractorôs letterhead; identify the name, title and phone number of the person who is sending the response; and, if applicable, include the memberôs AHCCCS ID number.

60.403 Time Frame for Filing an Appeal

A member or a provider acting as the designated representative and with the memberôs consent must appeal either orally or in writing to the CRS Regional Contractor within sixty (60) days after the date of the Notice of Action.

60.404 Standard Resolution of an Appeal

1. For standard resolution of an appeal, the CRS Regional Contractor shall resolve the appeal and mail the written Notice of Appeal Resolution (letter #7) to the member within thirty (30) calendar days from the day the CRS Regional Contractor receives the appeal.
2. If the member requests an extension of the 30-day time frame in subsection (1), the CRS Regional Contractor shall extend the time frame up to an additional fourteen (14) days.

3. If the CRS Regional Contractor needs additional information and the extension is in the best interest of the member, the CRS Regional Contractor shall extend the time frame in subsection (1) up to an additional fourteen (14) days. If the CRS Regional Contractor extends the time frame, the CRS Regional Contractor shall:
   A. Give the member written notice (Notice of Extension of Resolution using Sample letter #6) of the reason for the decision to extend the time frame, and
   B. Issue and carry out the resolution as expeditiously as the memberôs health condition requires but no later than the date the extension expires.

60.405 Expedited Resolution of an Appeal

1. The CRS Regional Contractor shall establish and maintain an expedited review process for appeals from a member/memberôs representative or the provider (in making the request on behalf of the member or supporting the memberôs request) that taking the time for a standard resolution could seriously jeopardize the memberôs life or health or ability to attain, maintain or regain maximum function.
2. The CRS Regional Contractor shall conduct an expedited appeal if:
   A. The CRS Regional Contractor receives a request for an appeal from a member/memberôs authorized representative and the CRS Regional Contractor determines that taking the time for a standard resolution could seriously jeopardize the memberôs life or health, or ability to attain, maintain, or regain maximum function;
   B. The CRS Regional Contractor receives a request for an expedited appeal from a member/memberôs authorized representative who believes that taking the time for a standard resolution could seriously jeopardize the memberôs life or health, or ability to attain, maintain, or regain maximum function;
   C. The CRS Regional Contractor receives a request for an expedited appeal directly from a provider, with the memberôs written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the memberôs life or health, or ability to attain, maintain, or regain maximum function.
3. For expedited resolution of an appeal, the CRS Regional Contractor shall resolve the appeal, make reasonable efforts to provide oral notice and mail the written Notice of Appeal Resolution to the member within three (3) business days from the day the CRS Regional Contractor receives the expedited appeal request.

60.406 Time Frame for an Expedited Appeal Resolution

1. If the CRS Regional Contractor denies a request for an expedited resolution, it must transfer the appeal to the 30-day time frame for a standard appeal. The CRS Regional Contractor must make reasonable efforts to give the CRS member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of the denial of an expedited resolution.
2. Expedited appeals must be resolved within three (3) business days of receipt of the request. If the member requests an extension of the 3-business day time frame, the CRS Regional Contractor shall extend the time frame up to an additional fourteen (14) days.
3. If the CRS Regional Contractor needs additional information and the extension is in the best interest of the CRS member, the CRS Regional Contractor shall extend the time frame up to an additional fourteen (14) days. If the time frame is extended, the CRS Regional Contractor shall:
   A. Give the member written notice (Notice of Extension of Resolution) of the reason for the decision to extend the time frame; and
   B. Issue and carry out the determination as expeditiously as the CRS memberôs health condition requires and no later than the date the extension expires.

60.407 Notice of Appeal Resolution

The CRS Regional Contractor shall use the Notice of Appeal Resolution letter # 7.

60.500 Request for Review Process by ALTCS/Acute Care Contractors

60.501 Request for Review Process

1. Request for Review means a request by an AHCCCS Health Plan/Program Contractorôs Medical Director asking the CRS Regional Contractor Medical Director to review a new service denial or a reduction, suspension, or termination of a previously authorized service for a Title XIX or Title XXI member (See the Notice of Action section in Chapter 80 for procedures related to sending out the denial notice).
2. When a denial is deemed a ónon-covered CRS service,ô the AHCCCS health plan/program contractor Medical Director may appeal the decision in writing with the CRS Regional Contractor Medical Director no later than ten (10) business days of the date of decision by asking for a Request for Review.

3. The CRS Regional Contractor Medical Director must respond within ten (10) business days from date of receipt of the Request for Review from the AHCCCS health plan/program contractor.
4. A Notice must be sent by the CRS Regional Contractor advising the ALTCS/Acute Care Contractor Medical Director of the review decision and of the right of the ALTCS/Acute Care Contractor, in the event that the ALTCS/Acute Care Contractor disagrees with the decision, to file a request for hearing with AHCCCS Administration within thirty (30) days of receipt of decision by the CRS Regional Contractor. See letter #8 at the back of this Chapter for the language to be included in the Notice.
5. If the ALTCS/Acute Care Contractor provides the service that CRS has denied, and the AHCCCS Hearing Decision determines that the service should have been provided by CRS, CRS shall be financially responsible for the costs incurred by the ALTCS/Acute Care Contractor in providing the care.

60.600 State Fair Hearing Process

60.601 Request for a State Fair Hearing

1. A member may request a State Fair Hearing of the CRS Regional Contractor resolution to uphold its original adverse decision.

60.602 Filing Timeframes

1. The CRS Regional Contractor will forward AHCCCS (Title XIX and Title XXI member) requests for State Fair Hearings to AHCCCS Office of Legal Assistance within five (5) business days of receipt.

   Office of Legal Assistance
   AHCCCS Administration
   701 East Jefferson
   Phoenix, AZ 85034
2. The CRS Regional Contractor will forward ADHS (non-AHCCCS member) requests for State Fair Hearings to CRSA within five (5) business days of receipt.

   Arizona Department of Health Services
   Office of the Director
   Counsel and Legal Support Unit
   150 North 18th Avenue, Suite 500
   Phoenix, Arizona 85007-3247

60.603 Request for an Expedited State Fair Hearing

A member may request an expedited State Fair Hearing on the CRS Regional Contractor resolution of an expedited appeal. The request shall be in writing, submitted to and received by the CRS Regional Contractor no later than thirty (30) calendar days after receipt of the CRS Regional Contractor Notice of Appeal Resolution.

60.604 Time Frame for Resolution of an Expedited State Fair Hearing

Within three (3) business days of the receipt of a response from an expedited State Fair Hearing for AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members), AHCCCS or ADHS shall mail to the member the response from the State Fair Hearing. AHCCCS or ADHS shall make reasonable efforts to provide oral notice of the decision.

60.605 Denial of a Request for a State Fair Hearing

1. AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) shall deny a request for a State Fair Hearing under A.R.S. § 41-1092, et seq., upon written determination that:
   A. The request for hearing is untimely;
   B. The request for hearing is not for an action permitted under this policy;
   C. The request for hearing is moot, based on the factual circumstances of each case, as determined by AHCCCS or ADHS, based on factual circumstances of each case; or
   D. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all enrollees.

60.606 Withdrawal of a Request for a State Fair Hearing

1. AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) shall accept a written request for withdrawal from the member if the Notice of Hearing has not been mailed.
2. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) has mailed a Notice of Hearing, AHCCCS (Title XIX and Title XXI members) shall forward the written request for withdrawal to the AHCCCS Office of Legal Assistance (OLA) or ADHS (non-AHCCCS members) will forward the written request for the withdrawal of the Notice of Hearing to the ADHS Counsel and Legal Support Unit.

60.607 Processing Request for a Hearing

1. If the member files a request for hearing, CRS Regional Contractors must ensure that the case file and all supporting documentation is received by the AHCCCSA, Office of Legal Assistance (Title XIX and Title XXI members), or ADHS (non-AHCCCS members) within five (5) business days of receipt of the request. The file provided by CRS Regional Contractors must contain a cover letter that includes:
   A. CRS member's name, AHCCCS ID number, address, and phone number (if applicable);
   B. Date of receipt of appeal;
   C. Summary of the CRS Regional Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution;
   D. The CRS member's written request for hearing;
   E. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
   F. Copy of CRS Regional Contractor's Notice of Appeal Resolution; and
   G. Other information relevant to the resolution of the appeal.

60.608 Continuation of Services While the CRS Regional Contractor Appeal and the State Fair Hearing are Pending

1. For the purposes of this Section, timely filing means filing on or before the later of the following:
   A. Within ten (10) calendar days after the date that the CRS Regional Contractor mails the Notice of Action, or
   B. The effective date of the action as indicated in the Notice of Action.
2. The CRS Regional Contractor shall continue the member's services if:
   A. The member files the appeal timely;
   B. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
   C. The services were ordered by an authorized CRS provider;
   D. The original period covered by the original authorization has not expired; and
   E. The member requests continuation of services.
3. If, at the member's request, the CRS Regional Contractor continues or reinstates the member's services while the appeal is pending, the CRS Regional Contractor shall continue services until one of the following occurs:
   A. The member withdraws the appeal;
   B. Ten (10) calendar days pass after the CRS Regional Contractor mails the Notice of Appeal Resolution to the member, unless the member, within the 10 calendar day time frame, has requested in writing a State Fair Hearing with continuation of benefits until the CRS Regional Contractor decision is reached;

C. AHCCCS (Title XIX and Title XXI members) or CRSA (non-Title XIX and non-Title XXI members) mails a decision adverse to the member; or
D. The time-period or service limits of a previously authorized service have been met.

4. If AHCCCS (Title XIX and Title XXI members) or CRSA (non-Title XIX and non-Title XXI members) upholds the CRS Regional Contractors action, the CRS Regional Contractor may recover the cost of the services furnished to the member while the appeal is pending if the services were furnished solely because of the requirements of this policy.

60.609 Reversed Appeal Resolution

1. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the CRS Regional Contractor shall provide the disputed services promptly, and as expeditiously as the memberôs health condition requires.
2. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CRS Regional Contractor shall pay the provider for those services.

60.608 Providers

The grievance process for CRS staff and contracted providers follows the same guidelines as described in section 60.300.

60.700 Tracking and Trending of Member and Provider Grievances

1. Contractors must ensure that member health records, as well as the records described in 60.202, are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse and grievances. Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, HIPAA and 42 CFR 431.300 et seq.
2. Information related to coverage and payment issues must be maintained for at least five years following final resolution of the issue, and must be made available to the member, provider and/or CRSA authorized staff upon request.

3. The CRS Regional Contractor shall log and track all member/provider grievances, denials, appeals and state fair hearings, regardless of who within the organization receives the grievance, appeal or request for a state fair hearing.
4. The grievance, denial, appeal and state administrative hearing log must be completed using CRSA specified forms and/or databases.
5. The logs and/or databases must be submitted to CRSA by the 15th of the month for the preceding month.

Letter #1
Non-quality of care grievance acknowledgement letter *(On Regional Contractor letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the grievance)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

It is important to us that you are happy with the care and service that you get from us. We have received your complaint and we will be looking into it. As soon as possible, we will send you a response.

Thank you for letting us know about your problem. If you have any questions, you can call XXXXX, at (602) XXX-XXXX.

Sincerely,

(*Name and credentials)*
(*Title*)

Cc:
XXX

Letter #2
Non-quality of care grievance resolution *(On Regional Contractor letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

DATE

(*Name of person filing the grievance)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We have looked at your complaint. We have found (or decided) . We have made this decision based on *(Please include the legal citations or authorities supporting the determination, if applicable.)*

Thank you for letting us know about your complaint. If you have questions, you may call me at (XXX) XXX-XXXX.

Sincerely,

*Name and credentials*Title

Letter #3
Appeal Acknowledgement Letter (On Regional Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the appeal)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We have received your appeal and will consider it. A written response will be sent to you within 30 days.

Thank you for contacting us about this issue. The quality of health care of all of our members is important to us. You can call XXXXXXXX, at (602) 000-0000 if you have any questions.

Sincerely,

Name and credentials Title

Cc:
XXXX

Letter #4
Request for Extension of Appeal Resolution Time Frame Letter (On Regional Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the appeal*
Address
City, State, Zip)

RE: *(CRS Member Name, Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We would like to take up to 14 extra days to look into your appeal. *).* These extra days to make a decision benefit you by allowing us to have more complete information about the services you want given. We will make every effort to complete our review as soon as possible. We will take no longer than a total of 44 days from the day we received your appeal.

On behalf of (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding. You can contact XXXXXXXX, at (602) 000-0000 if you have any questions regarding this issue.

Sincerely,

XXXXXXXXXXX
Name and credentials
Title
Cc: XXXX

Letter #5
Notice of Appeal Resolution *(On Regional Contractor letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

DATE
(Name of person filing the grievance
Address
City, State, Zip)

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We received your letter of (*Date)*, asking that we look again at our decision to _____ . (*repeat decision in layperson terms*)

We have looked at the decision again. We have decided (*that the first decision was right/* ***or****/ to change our decision to* [*describe decision in lay person's language*]_____. We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you can tell us you want a State Fair Hearing. You must ask for the hearing in writing within 30 days from the day you receive this Notice of Appeal Resolution. If we do not hear from you by then, our decision will be final.

If you are now getting a service that is being cut back or stopped, you have the right to ask that this service be continued during the time it takes to receive a decision from the State Hearing. You must ask for the State Fair Hearing and services to continue within ten calendar days from date of this letter. If the decision does not support your request, you may have to pay for the services in question.

If you have questions, you may call XXXX at (XXX) XXX-XXXX.

Sincerely,

Name and credentials

Title

Letter #6

(CRS Regional Contractor Letterhead)

Notice of Decision by CRS
on
AHCCCS Health Plan /Program Contractor Request for Review

I. Date

II.

III.

IV. To: Health Plan Name

V. Address

Re: (*Member name, CRS Member # and AHCCCS ID#*)

Dear: (*Plan Medical Director*)

We received your Request for Review dated _____ asking us to review our decision to _____.

After reviewing our original decision, we have decided (*that the first decision was right/* ***or****/ to change our decision to* _____.) We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you may file a request for a hearing with the AHCCCS Administration within 30 days of receipt of this letter.

If you have questions, please call us at *(XXX) XXX-XXXX.*

Sincerely,

_____
CRS Regional Medical Director

QUALITY OF CARE CONCERN SEVERITY LEVELS

Level 0- Track only:

No risk for it to be a quality of care concern, risk of harm, permanent damage, increased cost of care, lengthened stay, permanent damage, or potential media event. Concerns may be related to physical elements of the clinic and discourtesy.

Level 1- Concern that MAY impact the member if not resolved:

Potential unsafe home environment; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue.

Level 2- Concern that WILL impact the member if not resolved:

Including slow, or no responsiveness to a request for evaluation, treatment other request; member rights violation; inadequate case management; physician clinic cancellations; availability/timeliness of transportation for medical appointments.

Level 3- Concern that IMMEDIATELY impacts the member and is considered life threatening or dangerous

Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCS Director's Office.

Level 4- Concern that no longer impacts the member but may have potential to be life threatening or dangerous to other members:

Unexpected death has resulted, directly or indirectly as a result of care given or omitted. Media coverage assured. Lawsuit filed or in process.
Examples include cases abuse and neglect; unexpected deaths; and cases from the Governor's Office, Legislature, or ADHS Director/Assistant Director's Office regardless of the nature

PRIORITY CATEGORY OF GRIEVANCES

Priorities are categorized in four groups:

High Risk-Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; unexpected deaths; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCSA, ADHS Director's Office and or the Governor's Office.

Routine-Including slow, or no responsiveness to a request for evaluation, treatment other request; potential unsafe home environment; member rights violation; inadequate case management; availability/timeliness of transportation for medical appointments; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue. If there is absolutely no possibility that the complaint could impact the member in any way, it is to be tracked only, as a general grievance.

Track and Trend- Including non-quality-of-care concerns that may become quality of care concerns if a trend is identified.

Referral to other OCSHCN Sections, or other Agencies-Including eligibility issues; contract compliance; network issues; member fraud; compliance with statute or state plan; abuse or neglect; compliance with licensure standards; criminal offenses; etc. Fraud, abuse, neglect and criminal offenses are to be referred to the appropriate agency immediately upon identification.